



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

PRIDE  
5701 MAPLE AVENUE SUITE 100  
DALLAS TX 75235

#### **Respondent Name**

STATE OFFICE OF RISK MANAGEMENT

#### **Carrier's Austin Representative Box**

Box Number 45

#### **MFDR Tracking Number**

M4-13-0060-01

#### **MFDR Date Received**

SEPTEMBER 11, 2012

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "At this time we are seeking full reimbursement for the outstanding balance of \$4322.40... The total amount received as \$93.75 for DOS 9/27-9/28/00 which is why we have an outstanding balance of \$4,322.40. There is no valid reason why these claims should not have been processed and paid at the time they were initially submitted. The carrier did try to deny based on extent at one point and that issue was corrected when the claim were submitted and they were then denied for timely filing on some of them. Not all the claims were handled the same..."

**Amount in Dispute:** \$4,322.40

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The Office will maintain our denials as stated in the above chronological list for extent and medical necessity and respectfully request the Division to deem this dispute not eligible for review as it has been determined that the provider did not submit the medical fee dispute in accordance with Rule §133.307(e)(3)(C)(G)(H)."

**Response Submitted by:** State Office of Risk Management, PO Box 13777, Austin, TX 78711

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 20 through September 21, 2011 and September 27, 2011 through September 28, 2011	Chronic Pain Management	\$3,406.25	\$0.00
September 23, 2011	O/P SI Selective nerve root block	\$584.95	\$0.00
February 17, 2012 and May 3, 2012	Office Visits – CPT Code 99214	\$331.20	\$0.00

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 219 – Based on Extent of Injury
  - The comp injury is limited to lumbar sprain/strain only.
  - 29 – Time Limit for filing has expired.
  - W1 – Workers Compensation State Fee Schedule Adjustment
  - W3 – Additional payment made on appeal/reconsideration.

### **Issues**

1. Did the requestor submit bills for dates of service September 23, 2011, February 7, 2012 and May 3, 2012?
2. Was the requestor reimbursement for the disputed dates of service September 20-21, 2011 and September 27-28, 2011?
3. Is the requestor entitled to reimbursement?

### **Findings**

1. In accordance with 28 Texas Administrative Code §133.307(c)(2)(J), the requestor shall provide the following information and records with the request for MFDR in the form and Manner prescribed by the division... The request shall include: a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250. Review of the documentation submitted by the requestor finds that the medical bills for dates of service September 23, 2011, February 7, 2012 and May 3, 2012 were not included with the request for medical fee dispute resolution. Therefore, these dates of service are not eligible for review.
2. In accordance with 28 Texas Administrative Code §134.204, the requestor billed CPT Code 97799-CP-CA, 8 units each, for dates of service September 20, 2011 and September 21, 2011. The respondent initially denied the services using reason code "219 – Based on Extent of Injury". The respondent then denied the disputed dates of service using denial code "29 – Time limit for filing has expired." The respondent submitted a detail transaction records showing payment was issued with warrant number 127669407 on September 14, 2012 in the amount of \$2,000.00; therefore, the denial codes are not supported.

The requestor also billed CPT Code 97799-CP-CA, 8 units each, for dates of service September 27, 2011 and September 28, 2011 totaling \$2,000.00. The respondent initially paid \$593.75. The respondent submitted a detail transaction record showing payment was issued, in the amount of \$1,406.25, with warrant number 127669407.

The Division has determined that the requestor has been reimbursed in accordance with the Divisions applicable fee guideline.

3. Review of the submitted documentation finds that the requestor is not due additional reimbursement.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### Authorized Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
July 31, 2013  
Date

## YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**